Solicitation for State Proposals to Operate Qualified High Risk Pools

Application for the State of California

Submitted

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California Contact: Richard Figueroa
Deputy Cabinet Secretary
Office of the Governor
E-mail: richard.figueroa@gov.ca.gov
Phone: 916-319-9349
Fax: 916-324-6358

Responsible State Agency:
Managed Risk Medical Insurance Board
Lesley Cummings, Executive Director
P.O. Box 2769
Sacramento, CA 95812-2769
E-mail: lcummings@mrmib.ca.gov
Phone: 916-324-4695
Fax: 916-324-4878

Application Submitted to:
Department of Health and Human Services
Program Support Center
Strategic Acquisiton Services
Division of Acquisition Management
Parklawn Building, Room 5-101
5600 Fishers Lane
Rockville, MD 20857
highriskpools@cms.hhs.gov
pscaquisitions@psc.hhs.gov

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Proposal Certification

I, Richard Figueroa, attest to the following:

I have read the contents of the completed proposal and the information contained herein is true, correct, and complete. If I become aware of any information in this proposal that is not true, correct, or complete, I agree to notify the Department of Health and Human Services (HHS) immediately and in writing.

I authorize HHS to verify the information contained herein. I agree to notify HHS in writing of any changes that may jeopardize my State's ability to meet the qualifications stated in this proposal prior to such change or within 30 days of the effective date of such change.

I agree that if HHS approves this proposal and awards a contract to my State or State's designated high risk pool, that my State or State's designated high risk pool will abide by the requirements contained in the contract and provide the services as outlined in this proposal.

I agree that HHS may inspect any and all information necessary, including inspecting the premises of the high risk pool program's organization or contractors to ensure compliance with Stated Federal requirements. I further agree to immediately notify HHS if, despite these attestations, I become aware of circumstances which preclude full compliance with the requirements stated in this proposal.

I certify that I am authorized to certify this submission on behalf of my State or my State's designated entity.

Richard Figueroa — Deputy Cabinet Secretary

Richard Figueroa — 7/6/10

Authorized Representative Signature — Date

Background

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. PPACA contains a provision (Section 1101) requiring the federal government to establish a temporary federal high risk pool no later than 90 days after enactment to be terminated December 31, 2013. On April 2, 2010, Kathleen Sebelius, Secretary of the Department of Health and Human Services (DHHS) issued a letter to governors and state insurance commissioners asking each State to indicate its interest in administering the temporary high risk pool.

On April 29, 2010, Governor Arnold Schwarzenegger sent a letter to Secretary Sebelius indicating California's intent to contract with the federal government to operate a temporary health insurance program for currently uninsured individuals with preexisting medical conditions. On May 10, 2010, the federal DHHS agency released the application solicitation to establish the temporary federal high risk pool program that included an initial submission deadline of June 1, 2010 for contracts to be awarded on July 1, 2010.

Governor Schwarzenegger's letter indicated that California would operate the temporary high risk pool alongside the State's high risk pool, the Major Risk Medical Insurance Program (MRMIP), under the same governance and operational framework. The Managed Risk Medical Insurance Board (MRMIB) has administered MRMIP since its inception in 1991. The Board is comprised of volunteer members appointed by the Governor and the Legislature consistent with strict state conflict of interest standards. MRMIB is also responsible for administering California's Children's Health Insurance Program (CHIP), known as the Healthy Families Program (HFP) in California, under the federal requirements of Title XXI. MRMIB has successfully administered HFP since its inception in July 1998, and it is the nation's largest CHIP, with enrollment of nearly 900,000 children. Under Title XXI, MRMIB also administers the Access for Infants and Mothers Program (AIM) and the County Children's Health Insurance Program (CCHIP).

MRMIB has a demonstrated record of accomplishment in implementing four new programs with aggressive start-up timelines and successfully opening them on time. The Board contracts with administrative vendors for the day-to-day program operations under the oversight of MRMIB staff and with public and private health plans to provide health care coverage.

On June 29, 2010, the Governor signed legislation (SB 227 (Alquist), Chapter 31 of 2010 and AB 1887 (Villines), Chapter 32 of 2010) requiring MRMIB to establish and administer the new federal high risk pool program, contingent on an agreement with federal DHHS, and receipt of adequate federal funding for the program. The legislation passed on an urgency basis and became law immediately. The legislation prohibits the use of any state funds for the new federal program.

C.4 Technical Approach Content

C.4.1 Describe in detail the State proposal for establishing and providing for the ongoing administrative functions of operating a high risk pool program. The description should describe how the State proposes to make the high risk pool program operational, including all sub-contracting relationships that may be included in the implementation plan and a proposed timeline for the implementation of the high risk pool program that includes the first date on which the program will accept enrollments and the first date on which the program will provide coverage for subscribers. If the State operates another high risk pool, describe how the State will segregate funding and expenditures for the two programs and track subscribers separately across all benefits and services.

C.4.1 Response

California will establish and operate at the state-level the federal Pre-existing Conditions Insurance Plan (PCIP), using a model similar to the state's current high risk pool program, MRMIP, which is operated through a public-private partnership with contracted vendors supervised and monitored by MRMIB. California expects to begin accepting applications in August 2010 for coverage that will begin in September 2010.

MRMIB is issuing a solicitation for selection of one or more entities to provide administrative vendor (AV) services and to perform third party administrator (TPA) activities.

The contracted AV will have responsibility for eligibility and enrollment services, billing and premium collection and coordination, operation of first-line customer service functions, first-level appeals of eligibility determinations and administration of an independent external review of adverse coverage decisions made by the TPA.

The contracted TPA will be responsible for offering and managing a contracted provider network; processing and paying provider claims; utilization review and utilization management; benefit management, provider relations and provider complaints, first-level appeals of benefit and coverage decisions; and responding to subscriber questions and complaints regarding the provision of benefits. The TPA contractor will also be responsible for all sub-contracting relationships to fully administer the benefits and claims processing function, including contracts with a statewide network of health care providers, a subcontract or arrangement with a pharmacy benefit manager and other subcontractors as may be needed to meet all federal and state requirements.

There will be a separate AV for the PCIP and the MRMIP. Separate vendors for the two programs will ensure that MRMIB can account for PCIP program revenues and MRMIP revenues separately in all reporting and accounting processes. MRMIB will ensure that all premium revenues and interest earned are used for the costs of the PCIP.

C.4.2 Program Design

In response to the questions below, describe how the State will design a high risk pool program that will meet the basic requirements to operate the program as described in A.4.2 of the Statement of Work.

C.4.2.1 Describe the eligibility criteria that the qualified high risk pool will use to determine if individuals are eligible to enroll in the proposed high risk pool program.

C.4.2.1 - Eligibility Criteria

The California PCIP will enroll individuals meeting the following eligibility criteria. To be eligible, an individual must be:

1) A resident of the state of California;
2) A citizen or national of the United States or lawfully present in the United States (as determined in accordance with section 1411);
3) Not covered under creditable coverage (as defined in section 2701(c)(1) of the Public Health Service Act as in effect on the date of enactment of the PPACA) for a continuous period of six months prior to the date on which such individual is applying for coverage through the PCIP; and,
4) An individual with a pre-existing condition, demonstrated by one of the following:

    a. Evidence of denial of individual health coverage; or,
    b. Evidence of the offer for an individual, not a group, health insurance plan with a premium rate in excess of the subscriber rate for a preferred provider organization (PPO) benefit plan in the Major Risk Medical Insurance Program in the geographic region where the individual is seeking coverage. (MRMIP rates are set in statute at 125-137% of the standard risk rate.)

C.4.2.2 Describe the coverage and benefits to be offered by the qualified high risk pool. At a minimum, the response to this question must address the benefits elements contained in A.4.2 of the Statement of Work and include all benefit plan variations that may be proposed by the State.

C.4.2.2 - Coverage and Benefits

The benefit plan to be offered in California's PCIP will cover a broad scope of medically necessary health care services in a Preferred Provider Organization (PPO) model plan. Subject to final approval by the MRMIB, the benefit plan will require that subscribers satisfy a $1,500 annual deductible for in-network medical services, with a separate $500 deductible for brand name drugs, and pay a 15% coinsurance for in-network services, (except for a $25 copayment for physician office visits) up to an annual out-of-pocket limit of $2,500. Higher cost sharing will apply for services outside of the PPO network,

with a 50% coinsurance for most services and no maximum annual out-of-pocket limit. Preventive care services will be covered with no subscriber cost sharing requirements. There will be no annual or lifetime benefit limit. The California PCIP will cover the following services if medically necessary:

- Hospital services;
- Physician office visits;
- Diagnostic X-ray and lab services;
- Prescription drugs;
- Durable medical equipment;
- Ambulance services;
- Emergency health care services;
- Mental health care services;
- Home health care services;
- Skilled nursing services (covered only as a medically appropriate cost-effective alternative to other services); and,
- Physical, occupational and speech therapy.

A detailed program benefit summary is attached as Appendix A.

C.4.2.3 How will the qualified high risk pool comply with the requirements to cover pre-existing conditions described in A.4.2.3?

C.4.2.3 - Pre-existing Conditions

The health coverage provided by California's PCIP will include access to covered services, including emergency services, without limitation or exclusion of benefits relating to a condition present before the first day of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. The contracts for TPA benefits management in the PCIP will prohibit imposition of a pre-existing medical condition exclusion or any waiting period because of a pre-existing medical condition.

C.4.2.4 Describe how the qualified high risk pool will derive its premiums, including a description of its methodology in determining the standard risk rate.

C.4.2.4 - Premiums and Standard Risk Rate

California will develop premium rates for the PCIP as follows:

Market Survey. The MRMIB will establish and adopt the premium rates to be paid by PCIP subscribers. MRMIB, working with outside consultants, will conduct an annual market survey of the health plans with the largest individual coverage market share in California as close to January 1 of each year as possible. The survey's purpose will be to identify the top-selling individual products and obtain information about the benefit

features and average sold premiums for the individual products. MRMIB will incorporate information about average underwriting loads applied by California health plans in the development of the PCIP standard rates. As there is no mechanism to require health plans to cooperate with the market survey efforts, differences in participation from year-to-year may be expected. MRMIB will make every effort to minimize the impact of changes in survey participation on the PCIP rates. As appropriate, the information provided directly by health plans will be augmented with information available from other sources, including premium rates available through insurer web sites.

From the results of the market survey and information gained through alternative sources, MRMIB will select a subset of the top-selling individual products on which to base the PCIP premiums. The selected products will be those that are reasonably similar in design to the PCIP benefit plan with an objective of including at least one product from each surveyed health plan.

Actuarial Adjustments. MRMIB will work with actuarial consultants to develop and apply actuarial benefit adjustments to reflect benefit differences between the selected top-selling individual products and the PCIP benefit plan. To the extent there is wide variation in the reported premium rates for the market products, and enrollment data are available, the rates will be weighted by enrollment. If such data are not available, a simple average will be used. Assistance from the health plans in the development of the benefit adjustments will be utilized to the extent possible and appropriate.

The following actuarial adjustments will be made to the standard plan rates obtained:

- Standard premiums for each selected individual product will be multiplied by the actuarial benefit factors to produce premium rates reflective of the PCIP benefit design; and,
- Adjustments to convert the premium rates based on the health plans' region definitions to premium rates based on the PCIP geographic regions.

The premium rates for each top-selling individual product adjusted as described above will be averaged to produce a single set of age-based premium rates for the PCIP. PCIP premiums will vary by age band, and will be limited to a range of 4:1 (i.e., the most expensive premium will not be greater than four times the cost of the least expensive premium within a geographic region), for age bands covering subscribers between the ages of 19 and 64. PCIP premiums will vary among the six geographic regions used for California's existing high risk pool (included as Appendix B).

Premium rates will be adjusted January 1 of each year. Due to differences in the magnitude and timing of rate changes implemented by each health plan, as well as to smooth the rate changes from year-to-year, assumptions about expected premium increases may be applied in the development of the standard premium rates effective

each January 1.

The proposed benefit plan will comply with the federal requirement that the PCIP cover at least 65% of the costs of covered health services.

C.4.2.5 Describe the cost sharing structure of the benefit package(s) proposed to be offered by the qualified high risk pool that complies with the requirements outlined in A.4.2.7.

C.4.2.5 - Cost Sharing Structure

Subject to final approval by MRMIB, the currently anticipated PCIP benefit plan will require that subscribers satisfy a $1,500 annual deductible for in-network medical services with a separate $500 annual deductible for brand name drugs, require a 15% coinsurance for most in-network services, (there will be a $25 flat rate copayment for physician office visits), and cap annual out-of-pocket subscriber costs at $2,500. Higher cost sharing will apply for services outside of the PPO network, with a 50% coinsurance for most services and no maximum annual out-of-pocket limit. Preventive care services will be covered with no subscriber cost sharing requirements.

The proposed out-of-pocket limit does not exceed the 2010 limit of $5,950 imposed for Health Service Account plans pursuant to Section 223(c)(2) of the Internal Revenue Code.

C.4.2.6 If applicable, describe the provider network(s) proposed to be used by qualified high risk pool subscribers and demonstrate that the network(s) has a sufficient number and range of providers to ensure that all covered services are reasonably available and accessible in those networks.

C.4.2.6 - Provider Network

The PCIP will offer a PPO benefit plan design. MRMIB is in the process of conducting a vendor solicitation for a TPA vendor. The TPA contract will require that the PPO network offered include a sufficient number and range of contracted providers in all 58 California counties so that all covered services are reasonably available and accessible to subscribers on an in-network basis. The network must include a full range of providers, including but not limited to, primary care physicians, specialists, hospitals, and behavioral health, ancillary, and pharmacy providers.

MRMIB will require by contract that the TPA conduct appropriate provider credentialing and provider quality monitoring. MRMIB expects that the contracted TPA will adhere to a specific methodology for ensuring the adequacy of the network, including the availability of providers appropriate to meet the needs of high risk individuals, and to meet specific access standards. MRMIB will conduct a thorough review of the adequacy of the TPA network as part of the solicitation and contracting process and

during the course of operation of the PCIP will require the TPA to perform and report the results of regular network adequacy reviews.

Subscriber access to network providers must be consistent with industry best practices for an accessible delivery system. The provider contracts must contain hold harmless clauses that prevent network providers from charging subscribers for the difference between the allowed benefit and the provider's actual charge (balance billing), consistent with California law for PPO networks.

MRMIB will work to ensure that subscribers who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy at the time the TPA terminates either the subscribers' specialty provider contract or a PPO network contract, will be allowed to continue to see their specialty provider for up to 90 days or through their postpartum care.

At a minimum, MRMIB will require the TPA to offer a provider network that meets the standards outlined in the federal solicitation for TPA services in the federal high risk pool program administered by DHHS in states not operating a state-level program (federal fallback program). MRMIB may impose additional network access standards in the TPA contract, consistent with industry standards and relevant California law.

C.4.2.7 Describe the appeals and reconsiderations process that the qualified high risk pool proposes to make available to subscribers in the high risk pool program as per the description of section A.4.2.10.

C.4.2.7 - Appeals and Reconsideration

Appeal procedures will ensure applicants and subscribers have the right to file an appeal with at least two levels of review, one internal to the program and an administrative hearing. The first level of appeal will be internal to the program through the contracted AV for eligibility and enrollment related appeals and through the contracted TPA for appeals related to benefits and coverage decisions. Eligibility and enrollment appeal decisions include denial of eligibility; failure to make a timely determination of eligibility; and termination of enrollment, including disenrollment for failure to monthly premiums. Coverage and benefit decisions include denial of benefits or payments, coverage for specific treatments or procedures because of medical necessity criteria and services not covered or covered at a lower percentage because they are obtained out-of-network. The second level of appeal for both types of appeals will be an administrative hearing.

The appeals process will include an independent external review (IER) of adverse medical necessity coverage decisions made by the contracted TPA. To ensure that the IER is independent, MRMIB will include the IER component in the AV vendor solicitation and contract. The IER will, at a minimum, incorporate the consumer protections outlined in the Uniform External Review Model Act promulgated by the National

Association of Insurance Commissioners in 2004, and amended in April 2010. IER findings will be binding on the contracted TPA.

The process for all appeals will be outlined in the program handbook and in notification letters to applicants and subscribers. All decisions will be in writing and all decisions that have an impact on an applicant or subscriber will include instructions on how to file an appeal when an applicant or subscriber believes the decision was incorrect. Each applicant or subscriber will have the right to represent him or herself or choose a representative, the right to review their file and other relevant information and the right to participate fully in the appeal process. Any notification of a first-level appeal determination will include full notification of the second level appeal opportunity and the timelines and process for accessing the second level review.

C.4.3 Enrollment Standards

Describe the qualified high risk pool's proposed eligibility determination and enrollment standards as outlined in Section A.4.3.

C.4.3 - Eligibility Determination Process

MRMIB will contract with an administrative vendor (AV) to manage and administer the eligibility and enrollment process, as the state currently does in the MRMIP and the Healthy Families Program. The administrative vendor will be responsible for eligibility determinations, premium collection, transmission of enrollment information to the TPA, and printing and mailing of application materials.

The vendors' contracts will initially provide for a mail-in application to be processed within twenty days for complete applications; ten days for application processing by the AV and ten days for the TPA to provide subscribers with a health plan card, subscriber materials and the certificate of coverage booklet. MRMIB will work with the AV contractor with the goal of developing an online application.

Initially, the application and enrollment materials will be published in English and Spanish, and subsequently will be provided in any language that reaches a 5% threshold level of subscribers based on data collected at the time of application. For this purpose, the application will include a question to identify the primary language of the applicant. MRMIB will require the AV contractor to have trained bilingual staff and to operate a toll-free telephone line that can provide language interpetation services in any language requested by applicants and subscribers.

Completed applications submitted by the 10th of the month will be processed for an effective coverage date on the 1st day of the following month.

Similar to its administrative vendor contract for the Children's Health Insurance Program, MRMIB will establish performance requirements for process and accuracy. The AV contract will have a liquidated damages provision that requires the vendor to

pay liquidated damages if the required standards are not achieved. The Payment Error Rate Measurement (PERM) audit for California for CHIP found a very high rate of eligibility determination accuracy.

C.4.3.1 How will the qualified high risk pool develop and utilize an eligibility determination process that will assure that only individuals eligible for coverage, as described in Section A.4.2 of the Statement of Work, receive benefits from the program?

C.4.3.1 Eligibility Determination

As outlined in C.4.3 above, California will establish in the enrollment application and by contract with the AV contractor specific eligibility processing and documentation requirements for the each of the PCIP eligibility criteria. The PCIP program application will be designed to verify:

- State residency, as determined by the applicant having a California address or other appropriate documentation as determined by MRMIB;
- U.S. citizenship and immigration status of applicants, obtained through questions and required supporting documentation (see C.4.3.3 below);
- The applicant has been without creditable coverage for at least 6 months, based on a series of questions on the application, such as previous insurance coverage and availability of employer-sponsored coverage, and combined with an applicant attestation that they have been without insurance coverage for six months; and,
- The applicant has a pre-existing condition, to be confirmed by either a notice of rejection for individual coverage from a health plan or insurer, or proof of an offer of individual insurance at rates higher than PPO coverage in California's state high risk pool program, MRMIP (premiums are set in MRMIP at 125% of market rates).

C.4.3.2 How will the qualified high risk pool obtain all of the information described in Section A.4.2 of the Statement of Work as part of the proposal process in the high risk pool program?

C.4.3.2 Eligibility Documentation

MRMIB will develop and implement through the AV contractor an application to collect the information required including name, address, date of birth, social security number, contact information and appropriate information and documentation to verify eligibility as described above. MRMIB is currently reviewing whether to develop a separate and new application for the PCIP, distinct from the state MRMIP, or to combine the applications. In either case, MRMIB will ensure the application collects the information and documentation necessary to verify eligibility and prioritizes timely enrollment of persons eligible for both programs.

C.4.3.3 Describe the process that the qualified high risk pool will use to confirm that a subscriber is a citizen or national of the United States or an alien lawfully present in the United States.

C.4.3.3 Citizenship Verification

MRMIB will establish, by regulation and by contract, the acceptable documentation to confirm that an applicant is a citizen, national or alien lawfully present in the United States, consistent with federal requirements. Applicants will be required to provide hard copy documentation, (including the applicant's Social Security number), which will include, but may not be limited to: certified copies of birth certificates; U.S. passports; Native American tribal documents; or legal certificates of U.S. citizenship or naturalization issued by the federal government.

After the initial implementation of the PCIP, California will assess the feasibility of establishing interfaces with the Social Security Administration (SSA) and the Department of Homeland Security (DHS) to conduct electronic administrative verifications of citizenship and immigration status. MRMIB would look to work collaboratively with DHHS to establish the connectivity with SSA for citizenship originally developed through CHIPRA in January 2010 and DHS for immigration status on a yet to be developed interface. If technically feasible and cost effective, these enhancements could help simplify the eligibility and enrollment process for the PCIP as well as the process envisioned for the state health insurance exchange to be established in 2014.

C.4.3.4 Describe the enrollment process that the qualified high risk pool proposes to use.

C.4.3.4 Enrollment Process

The AV will process and screen all applications for completeness and potential eligibility for either the PCIP and/or the MRMIP state high risk pool program. The AV contract will ensure the AV's functionality to process and screen mail-in applications and any other application methods or processes specified by MRMIB. MRMIB will require the AV, by contract, to forward applications for the state high risk pool to the MRMIP enrollment vendor for processing. The PCIP AV contract will provide for applications to be processed within twenty days for complete applications; ten days for application processing and ten days to provide subscribers with enrollment materials.

The AV will forward to the TPA the list of PCIP eligible persons on an ongoing basis. Subsequent to selection of the AV and TPA vendors, a determination will be made as to process for enrolled persons to receive the subscriber welcome packet, coverage identification card, provider directory, certificate of coverage and benefits and other appropriate subscriber materials as determined by MRMIB. MRMIB will develop procedures and contract requirements to ensure that subscribers enrolled in the PCIP

receive program materials in a timely manner, that enrollment processing between the AV and the TPA is seamless for the subscriber, and that subscribers have the necessary information they need to access services by their coverage effective dates.

Completed applications submitted by the 10th of the month will be processed for an effective coverage date on the 1st day of the following month.

Periodic enrollment caps may be necessary as a tool to manage the funds available for the program. The AV will be tasked with administering enrollment caps if instituted and any waiting lists that might be necessary. MRMIB will actively monitor enrollment and claims expenses to manage program costs and revenues on an ongoing basis. MRMIB has successfully managed the existing state high risk pool within budgeted resources through the strategic use of enrollment caps and subscriber waiting lists.

C.4.3.5 Describe the disenrollment process that the high risk pool plan proposes to use.

C.4.3.5 Disenrollment Process

MRMIB will establish final rules regarding reasons for disenrollment from the PCIP prior to program start-up. The reasons for disenrollment may include:

- At the request of the subscriber;
- Failure of the subscriber to make timely payment of premiums;
- The subscriber obtains other creditable coverage;
- Death of the subscriber;
- At any time that a subscriber fails to meet any eligibility requirements of the program; and,
- When subscribers are enrolled in a health insurance exchange or the federal act terminates, whichever is later.

The contracted AV will process subscriber disenrollments consistent with contract requirements and standards prescribed by MRMIB. Subscribers will have the opportunity for continuation of enrollment pending a disenrollment termination review. Prior to disenrollment, subscribers will receive a written disenrollment notification indicating the disenrollment reason with an enclosed pre-printed continued enrollment form request on which the subscriber has the opportunity to provide the necessary information or explanation as to why termination should not occur, in accordance with rules and requirements established for the PCIP. The subscriber will be notified of the right to appeal disenrollment decisions.

C.4.4 Describe the customer service functions and standards that will be employed by the qualified high risk pool program. The description should include the qualified high risk pool's proposal for the staffing, hours of operation

and service levels that the qualified high risk pool will provide to subscribers in the qualified high risk pool.

C.4.4 Customer Service

MRMIB will contract with an AV to operate a customer service call center that is appropriately staffed to be responsive to the number of plan subscribers and to provide prompt and accurate information and services to high risk pool program subscribers. At a minimum, the customer service call center will be available Monday-Friday from 8 a.m. to 5 p.m., with additional hours subject to vendor proposals received and subsequent contract negotiations.

MRMIB will require the AV, by contract, to have the capability to provide customer service and plan enrollment information in languages other than English as necessary to meet the needs of the population anticipated to be served by the PCIP and to make customer service and plan enrollment information available in formats that are accessible for subscribers with disabilities.

MRMIB will ensure the development of a single point of contact for subscribers through the AV and require the AV and the TPA to coordinate customer service functions so that subscribers need access only one customer service phone number for all types of issues, questions and complaints, whether related to eligibility or benefits. MRMIB will require the AV contractor to monitor the quality and accessibility of the call center services on an ongoing basis and to meet specified contract quality standards for customer service. MRMIB will ensure that the AV contractor complies with the federal contract requirement to respond to all subscriber correspondence within 20 days.

C.4.5 Describe the technical support center to respond to health care and pharmacy providers for information that will be employed by the qualified high risk pool. The description should include the qualified high risk pool's proposal for the staffing, hours of operation and service levels that the qualified high risk pool will provide.

C.4.5 Provider Technical Support

MRMIB will conduct a solicitation for and contract with the TPA to operate the technical support center for providers to meet state and federal requirements. MRMIB will require the TPA, by contract, to ensure that the technical support center is appropriately staffed to be responsive to the number of providers and the anticipated volume of calls based on the number of subscribers enrolled in the PCIP. At a minimum, the technical support center will be available Monday-Friday from 8 a.m. to 5 p.m. with additional hours subject to vendor proposals received and subsequent contract negotiations. MRMIB will require the TPA contractor to monitor the quality and accessibility of the call center services on an ongoing basis and to meet specified contract quality standards for customer service.

C.4.6 Describe the qualified high risk pool's system for billing, collecting, and accounting for premiums.

C.4.6 Billing and Collection

MRMIB will establish the procedures for billing, collecting and accounting for premiums by contract with the AV as it does now for the CHIP program. There will be a separate AV for the PCIP and the MRMIP. Separate vendors for the two programs will ensure that MRMIB can account for PCIP program revenues and MRMIP revenues separately in all reporting and accounting processes. MRMIB will ensure that all premium revenues and interest earned are used for the costs of the PCIP.

C.4.7 If the qualified high risk pool intends to develop and implement utilization and care management as part of the qualified high risk pool coverage, describe the utilization and care management processes that the qualified high risk pool proposes to use.

C.4.7 Utilization and Care Management

MRMIB is including in the vendor solicitation for the TPA contract a request for information on proposed utilization management, disease management, care management and a 24-hour nurse advice line for subscribers. MRMIB will contract with the TPA vendor for these services, contingent on contract negotiations once the vendor is selected.

Subject to final approval of contracts by the MRMIB, California anticipates the contracted TPA will be tasked with implementing and administering utilization management, disease management and care management services that will assure high risk pool subscribers have access to necessary services and prescription drugs in a cost-effective manner. MRMIB will focus on best value services, including prior authorization and concurrent review of inpatient medical services and management of specialty referrals.

The TPA Contractor will also be tasked with discharge planning and care coordination services for subscribers leaving the inpatient setting and care management services for selected subscribers with chronic illnesses or co-occurring behavioral health diagnoses, which typically include the coordination of medically necessary home and community-based services. MRMIB will look for a network with primary care providers who will be responsible for assisting subscribers in managing primary and specialty care.

The TPA Contractor will track and monitor the quality performance of the provider network including the number and type of specialty referrals made, the timeliness of the specialty referrals, and whether appropriate follow up occurs for each specialty referral. In addition, the TPA Contractor will have mechanisms to detect both under- and over-

utilization of health care services, focusing in particular on emergency room over-utilization and inappropriate inpatient admissions and lengths of stay.

MRMIB will ensure that the TPA Contractor conducts and reports periodic reviews of emergency room usage and implement measures to reduce inappropriate emergency room use if detected. The TPA Contractor will need mechanisms to notify primary care providers when utilization of services falls outside of established practice guidelines, so that primary care providers can work with subscribers to ensure appropriate service utilization.

C.4.8 Describe the system for processing and paying for health and prescription drug claims that will be implemented by the qualified high risk pool. The description should include the basis for payment rates and the timeliness of payments to providers. The description should also include the point of sale claim system that will be utilized for prescription drug claims.

C.4.8 Claims Payment

MRMIB anticipates that the TPA vendor will implement a system for timely and accurate payment of claims, including prescription drug claims, subject to the vendor proposals received and subsequent negotiation of contract terms. The TPA vendors may propose to work with subcontractors to provide the services, including a pharmacy benefits manager. MRMIB will ensure that the pharmacy management program includes the capability for point-of-sale claims for prescription drug services.

MRMIB will impose specific performance standards for the timely and accurate payment of claims consistent with, and subject to, negotiations related to the federal contract and contract negotiations with the selected TPA vendor. The TPA vendor will commit to specific percentages of clean claims paid timely and accurately within 30 calendar days of receipt. The PCIP claims processing system will encompass claims receipt through final payment, or denial, through a fully automated claim adjudication system that is consistent with industry standards for comparable commercial health insurance carriers or health plan administrators. The adjudication system should allow the TPA Contractor to ensure and monitor that claims are adjudicated in a timely and accurate manner.

California expects the TPA Contractor to ensure that at all times claims handling and claims payment processes and policies comply with all State and federal laws and contract requirements. At a minimum, the claims adjudication system will have the following capabilities:

- Automated eligibility verification that coverage has not terminated on the date of service;
- Benefit plan information stored on the system;

- Automatic calculation and tracking of subscribers' deductibles, coinsurance, copayments, and out-of-pocket limits and any other benefit such as limits on days, sessions, or visits, consistent with industry standards;
- Individual claim history stored on the system and automatically updated;
- Ability to distinguish claims by diagnosis code;
- Automated calculation of cost containment provisions;
- Identification and collection of claim overpayments;
- Procedures for review of "medically necessary" determinations; and,
- Automated production of an Explanation of Benefits.

The TPA Contractor, subject to terms and conditions established by the MRMIB, will establish provider payment rates in the PCIP. MRMIB anticipates that the rate methodology used will be consistent with the one used by the PPO for large employers. The TPA vendor solicitation will require prospective vendors to provide information on the rates and rate setting process and the MRMIB will select the contractor that provides the best overall value to the state.

Based on responses from potential vendors to the June 2010 Request for Information for this program, California will be working with DHHS in the contracting process to secure adequate claims reserves in advance, equivalent to at least three months of estimated claims, to ensure timely claims payment by the contracting TPA vendor.

C.4.9 Describe the qualified high risk pool's proposed efforts to conduct outreach and marketing for the high risk pool program.

C.4.9 Outreach and Marketing

California has already begun to respond to consumer inquiries regarding the California PCIP and is collecting the names of interested persons. MRMIB has established successful marketing and outreach programs for other programs it administers including the children's coverage program, HFP.

For this new program, MRMIB will task the AV with the lead responsibility to develop, conduct and support marketing and outreach activities as determined by MRMIB to be appropriate for the program and the population. MRMIB will work with the AV vendor and other state programs and agencies to notify potentially eligible individuals, and the organizations and providers who interact with them, about the availability of the California PCIP. The AV will also develop an Internet website for the program. The web site will serve as a platform for providing access to applications and communicating program rules.

MRMIB anticipates that the AV will, at a minimum, pay a fee to agents and brokers for facilitating a successful enrollment into the program.

In addition, one of the enabling bills, SB 227 (Alquist), requires California health plans and health insurers who deny someone individual coverage to include information about the potential for eligibility in MRMIP and the federal PCIP in the notice of denial.

C.4.10 Describe the process the qualified high risk pool proposes to use to identify and report to DHHS instances in which health insurance issuers or group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage in compliance with A.4.10.

C.4.10 Insurer Dumping

MRMIB will establish procedures to identify and report to DHHS instances where health insurance issuers or group health plans discourage individuals from remaining in existing coverage through the program application process and through partnership with the selected AV and TPA vendors.

The California PCIP program application will include questions to identify applicants (or their family members) that are employed, may have, or have had, access to other coverage including job-based group coverage, or may be getting assistance in the payment of premiums for PCIP from employers or other sources.

The MRMIB also expects to collaborate with the AV and TPA vendors to establish reasonable procedures to identify and ensure that these instances are promptly reported and passed on to DHHS.

C.4.11 Describe the procedures that qualified high risk pool proposes to implement to prevent, detect, and report incidences of waste, fraud, and abuse.

C.4.11Fraud and Abuse Prevention and Detection

MRMIB will conduct independent and objective audits, evaluations, and investigations to ensure program integrity. The CHIP program administered by MRMIB performed extremely well in the federal PERM audits. MRMIB will investigate written complaints received from any person or entity regarding fraud or abuse of the program. MRMIB will review existing and proposed legislation and regulations for guidance to ensure compliance with all state and Federal laws applicable to the PCIP.

In addition, MRMIB will require both the AV and the TPA contractors to implement fraud detection and prevention programs and to regularly report to MRMIB the experience and the results of those fraud detection efforts.

C.4.12 Describe the system for routine monitoring and identification of compliance risks.

C.4.12 Compliance Monitoring

MRMIB has an active internal federal compliance team that ensures on an ongoing basis that MRMIB programs comply with applicable state and federal laws. The vendor contracts for the AV and the TPA will require compliance with state and federal laws and the terms of California's contract with DHHS for the PCIP. The MRMIB compliance team will monitor internal compliance with PCIP contract requirements and work collaboratively with the MRMIB legal counsel and management team, as well as the contracted AV and TPA vendors to ensure compliance with all terms of conditions of the federal PCIP contract and program.

C.4.13 Describe the system the qualified high risk pool proposes to implement to coordinate benefits as described in A.4.13.

C.4.13 Coordination of Benefits

MRMIB will task the contracted TPA with coordinating benefits for PCIP subscribers. The vendor solicitation requests that potential TPA vendors recommend and propose systems they will implement to ensure coordination of benefits with other sources of coverage, such as workers' compensation and automobile medical coverage.

C.5 Cost Proposal

Budget Narrative

I. Projected Administrative Costs (Table 1)

The projected budget assumes that California will spend no more than 10% of total program revenues (federal allotment plus projected premium revenues) over the life of the PCIP, for a total of $126.7 million projected administrative costs.

There are two administrative cost components, contracted services and state agency costs. Actual administrative costs are subject to vendor selection and contract negotiations.

Contracted Services

There are three components to estimated contracted administrative services:

Administrative Vendor Services -- The Contracted AV will be responsible for eligibility/enrollment, marketing and outreach, member materials, customer service, information technology, premium administration, appeals and reconsiderations, accounting services and related activities.

Third Party Administrator Services -- The Contracted TPA will be responsible for provider network development and maintenance, provider relations, benefits administration, claims processing, utilization review, care management, accounting services, claims reconciliation and other related activities.

Other Contracted Services -- Includes legal, actuarial and evaluation consulting services.

State Agency Costs

There are two components to state agency administrative costs:

State personnel -- Includes the projected costs for MRMIB staff and related equipment and support for program administration and contract oversight.

Administrative Appeals and Fraud Investigations -- Includes the costs of interagency services to conduct administrative hearings for subscriber appeals and investigate fraud complaints.

Table 1 - Projected Administrative Costs						
Cost Category	**Annual Administrative Costs**					**Total**
	2010	**2011**	**2012**	**2013**	**2014**	
CONTRACTED SERVICES						
Administrative Vendor Contract						
TPA Contract						
Other Contracted Services						
Total Contracted services	$14,085,750	$28,161,500	$28,161,500	$28,161,500	$14,055,750	$112,626,000
STATE AGENCY						
Personnel Expenses	1,738,000	3,476,000	3,476,000	3,476,000	1,738,000	13,904,000
Overhead*						
Other Administrative Costs*						
(Administrative Appeals & Fraud Investigation)	20,000	50,000	50,000	50,000	50,000	220,000
TOTAL PROJECTED COSTS	$15,843,750	$31,687,500	$31,687,500	$31,687,500	$15,843,750	**$126,750,000**

II. Projected Administrative and Claims Costs (Table 2)

California's federal allotment for the PCIP is $761 million over the life of the program. Pricewaterhouse Coopers (PwC) estimates that premium revenues for the California PCIP will be approximately $506 million total over three years. The total projected available revenues for the program will be $1.2 billion.

Premium Revenue Methodology. MRMIB contracted with PwC to provide actuarial and consulting support in developing estimated premium revenues and projected enrollment. PwC-developed projections were made with the most accurate data available; but the estimates are subject to change as more information becomes available and final decisions are made with regard to program design. The PwC certification is attached (Appendix C).

California proposes to offer a single plan option with an actuarial value above the required 65% minimum. For purposes of the estimate, the PwC projections assume the final benefit plan design adopted by MRMIB has a $1,500 calendar year deductible, 15% coinsurance for most in-network services, and $2,500 annual out-of-pocket maximum. The actual benefit plan design is subject to final approval by the MRMIB.

The claim cost and age distribution assumptions underlying the projections are primarily based on recent experience of the MRMIP, California's existing state high risk pool, and the Guaranteed Issue Pilot Program (GIP, consisting of former MRMIP participants). The actuarial projections include average incurred claim costs of $980 per month in 2010 and claim cost trends of 10% per year. The projected total administrative costs over the life of the plan are assumed to be 10% of the total cost of the program.

For the average premium in the projections, PwC analyzed premiums for a large California insurer's top selling individual benefit plans in 2009 and early 2010, and applied actuarial benefit adjustments to convert the rates to the anticipated PCIP benefit plan. A 5% risk load was applied to the insurer's published rates to reflect an average underwriting adjustment applied by carriers to higher risk applicants. PCIP premiums will vary by age band, and the projections assume that the age distribution of PCIP subscribers will be similar to that in MRMIP. Initial estimates are that this would result in an average estimated premium of approximately $440 per month in 2010. The cost proposal assumes premiums will be reset each January 1 and that the average premium increase would be 10% per year. Actual PCIP premiums will be based on the results of a market survey and actuarial adjustments as described in the response to C.4.2.4.

Based on the assumptions described above, the projection produces an estimate of 24,150 subscribers that can be supported on a monthly basis under California's federal allotment of $761 million. This result assumes that these slots will be filled on the first day of operation. It further assumes that disenrolled subscribers will immediately be replaced by new subscribers.

PwC Enrollment Projection

	2010	2011	2012	2013
(Stated as annual member months)	**98,200**	**294,600**	**294,600**	**294,600**

Table 2 - Projected Administrative and Claims Costs
(One Benefit Plan Option)

Year	Average Monthly Enrollment	Premium Revenue	Total Claims	Administrative Costs	Total Claims Against Federal Fund Allotment
2010	24,150	$42,481,000	$85,756,000	$15,843,750	$59,118,750
2011	24,150	140,186,000	306,947,000	31,687,500	198,448,500
2012	24,150	154,205,000	339,549,000	31,687,500	217,031,500
2013	24,150	169,625,000	373,455,000	31,687,500	235,517,500
2014			35,040,000	15,843,750	50,883,750
TOTAL		**$506,497,000**	**$1,140,747,000**	**$126,750,000**	**$761,000,000**

Claims Reserve

California intends to establish a prudent claims reserve of at least three months of estimated claims revenues for the PCIP. Potential TPA vendors have indicated that a claims reserve is required to ensure timely payment and processing of claims to maintain an adequate provider network. California will draw down federal funds to establish the claims reserve based on a reasonable estimate of the first three months of start-up and will draw down federal funds based on estimated claims to maintain three months reserve at all times.

California also proposes to use a prudent budgeting strategy by accounting for the total anticipated costs of providing coverage to each subscriber, for the expected length of the person's enrollment, at the time the subscriber first enrolls. California expects to make this successful approach part of its contract with DHHS.

Maintenance of Effort Description (Table 3)

The budget narrative should contain a separate section that describes how the State proposes to meet the maintenance of effort requirement set forth in section 1101(b)(3) of the Affordable Care Act. A State should provide a narrative description of its maintenance of effort strategy and also provide a table identifying State allocated funds and other current State high risk pool program revenues that supplemented premiums paid by current state high risk pool program enrollees in 2009. The narrative and accompanying table should demonstrate that the State will maintain that level of support of its state high risk pool programs.

California state law (Chapter 1168, Statutes of 1989) created the MRMIP to provide health insurance through a high-risk pool to medically uninsurable Californians. The MRMIP is funded by a combination of subscriber premiums and Proposition 99 (tobacco tax) funds. MRMIP subscribers pay monthly premiums at rates set in statute between 125 percent and 137.5 percent of standard rates for comparable coverage in the private insurance market. Currently premiums are 125% of market rates. The State reimburses carriers participating in the MRMIP for nearly all costs that exceed the amount of premiums paid to the carriers by subscribers. The Governor's 2009-10 May Revise Budget Proposal, approved by Legislature provided the MRMIP $31.8 million for the 2009-10 fiscal year.

SB 1379 (Ducheny), Chapter 607, Statutes of 2008, also provides that any amount over the first $1 million in fines and penalties collected by the Department of Managed Health Care (DMHC) shall be transferred to the Major Risk Medical Insurance Fund and used to fund the MRMIP. The amount of fines and penalties imposed on health plans regulated by DMHC varies year-to-year and are not accounted for as state revenues. California does not consider such funds to be subject to the PCIP maintenance of effort requirement. In 2009, the amount of health plan fine revenues was approximately $1 million.

During the period of time that the PCIP is in operation, the State fully intends to comply with the maintenance of effort requirement and maintain funding for MRMIP at **$31.8 million** on an annual basis.

Table 3 Maintenance of Effort 2009-10 MRMIP Revenues ($ in thousands)		
Source of Revenue	**Amount**	**Percent**
Premiums[1]	$52,512	62%
Proposition 99	$31,834	37%
Fines and Penalties	$1,041	1%
Total	**$85,387**	**100%**

[1] Premiums are paid directly to participating health plans.

Appendix A

California PCIP

Preliminary Summary of Benefits

Type of Service	*Description of Service*	*What You Pay* *Participating Provider*	*What You Pay* *Non-Participating Provider*
Annual Deductible	The amount that a member must pay for covered services except for preventive care services before the plan will cover those services at the copayment or coinsurance amount in one calendar year	$1,500 per member	Not Applicable
Annual Deductible - Brand Name Prescription Drugs	The amount that a member must pay for brand name drugs before the plan will cover those drugs at the copayment or coinsurance amount in one calendar year	$500 per member	Not Applicable
Copayment/Coinsurance	Member's amount due and payable to the provider of care	See Below	
Annual Maximum Copayment/ Coinsurance Limit	Member's annual maximum copayment/coinsurance limit when using participating providers in one calendar year • The annual maximum copayment/coinsurance includes the $500 brand name prescription drugs annual and the $1,500 annual deductible • If nonparticipating providers are used, billed charges which exceed the customary and reasonable charges are the member's responsibility and do not apply to the annual maximum copayment/coinsurance limit	$2,500 per member	No annual maximum copayment/coinsurance limit for non-participating providers. You pay unlimited coinsurance
Annual Benefit Maximum	There is no annual benefit maximum in this program	N/A	N/A
Lifetime Benefit Maximum	There is no lifetime benefit maximum in this program	N/A	N/A
Preventive Care Services**	Services • Breast Exams, Pelvic Exams, Pap Smears, and Mammograms for Women, Human Papillomavirus (HPV) screening test, Ovarian and Cervical Cancer Screening, Cytology Examinations, Family Planning Services, Health Education Services, Periodic Health Examinations and Laboratory Services in connection with them, Hearing and Vision Exams for Children, Newborn Blood Tests, Prenatal Care (care during pregnancy), Prostate Exams for Men, Sexually Transmitted Infections (STI) tests, Human Immunodeficiency Virus (HIV) Testing, Well-Baby and Well-Child Visits, Certain Immunizations for children and adults, and Disease Management Programs	N/A	50% of customary and reasonable charges and any in excess
Hospital Services	• Inpatient medical services (semi-private room) • Outpatient services; ambulatory surgical centers	• 15% of negotiated fee rate • 15% of negotiated fee rate	• 50% of customary and reasonable charges and any in excess • 50% of customary and reasonable charges and any in excess
Physician Office Visits	Services of a physician for medically necessary services	$25 copayment per visit	50% of customary and reasonable charges and any in excess
Diagnostic X-ray and	Outpatient diagnostic X-ray and laboratory services	15% of negotiated fee rate	50% of customary and reasonable

California PCIP

Preliminary Summary of Benefits

Type of Service	*Description of Service*	*What You Pay* *Participating Provider*	*What You Pay* *Non-Participating Provider*
Lab Services			charges and any in excess
Prescription Drugs	• Maximum 30 day supply per prescription when filled at a participating pharmacy	• $5 for generic drugs $15 for brand drugs after the $500 brand name deductible is met	All charges except 50% of drug limited fee schedule for generic or brand name drugs
	• At least a 60-day supply for mail order	• $5 for generic drugs through mail service prescription drug program $15 for brand drugs through mail service prescription drug program after the $500 brand name deductible is met	
Durable Medical Equipment and Supplies	Must be certified by a physician and required for care of an illness or injury	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Pregnancy and Maternity Care	• Inpatient normal delivery and complications of pregnancy	• 15% of negotiated fee rate	• 50% of customary and reasonable charges and any in excess
	• Prenatal care **	• N/A	• 50% of customary and reasonable charges and any in excess
	• Postnatal care	• 15% of negotiated fee rate	• 50% of customary and reasonable charges and any in excess
Ambulance Services	Ground or air ambulance to or from a hospital for medically necessary services	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Emergency Health Care Services*	Initial treatment of an acute serious illness or accidental injury. Includes hospital, professional, and supplies	15% of negotiated fee rate	50% of customary and reasonable charges or billed charges, whichever is less plus any charges in excess of customary and reasonable for the first 48 hours
Mental Health Care Services***	• Inpatient basic mental health care services 10 days each calendar year	• 15% of negotiated fee rate and all costs for stays over 10 days	• 50% of customary and reasonable charges and any in excess and all costs for stays over 10 days
	• Outpatient basic mental health care services 15 visits each calendar year	• 15% of negotiated fee rate for 15 visits per year and all costs over 15 visits	• 50% of customary and reasonable charges and any in excess and all costs over 15 visits
	*** Unlimited inpatient days and outpatient visits for Severe Mental Illnesses and Serious Emotional Disturbances in children		
Home Health Care	Home health services through a home health agency or visiting nurse association	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess

California PCIP

Preliminary Summary of Benefits

Type of Service	*Description of Service*	*What You Pay Participating Provider*	*What You Pay Non-Participating Provider*
Hospice	Hospice care for members who are not expected to live for more than 12 months	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Skilled Nursing Facilities	Skilled nursing care	Not covered unless determined to be a medically appropriate more cost-effective alternative plan of treatment	
Infusion Therapy*	Therapeutic use of drugs, or other substances ordered by a physician and administered by a qualified provider	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess for all infusion therapy related administrative, professional, and drugs
Physical/Occupational/ Speech Therapy	Services of physical therapists, occupational therapists, and speech therapists as medically appropriate on an outpatient basis	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess

* For exact terms and conditions of coverage, refer to your Certificate of Coverage booklet.

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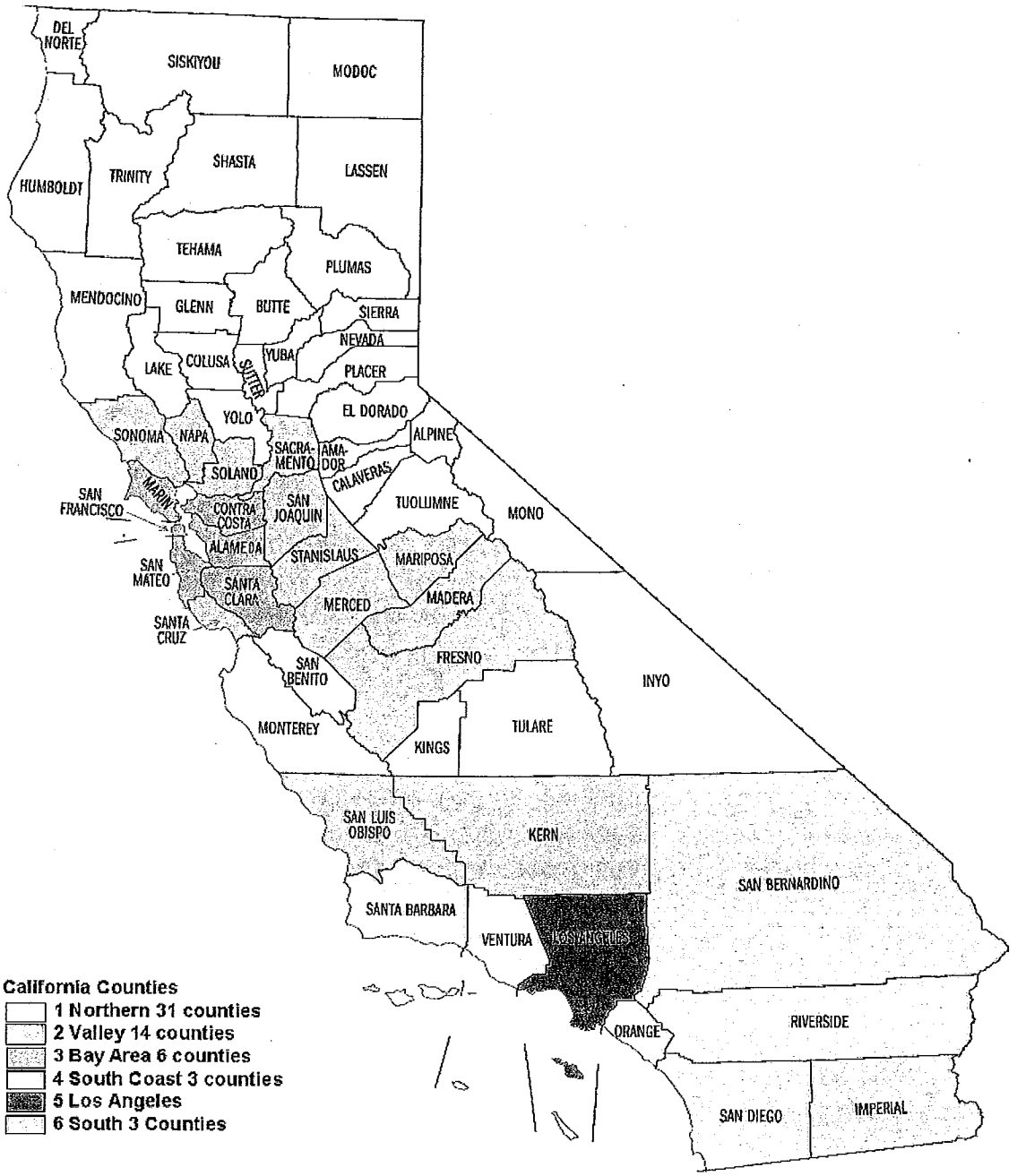
** These preventive care services are covered even if you have not met the annual deductible.

Appendix B
Proposed Geographic Regions



Appendix C

Actuarial Certification of the Cost Proposal for the California Temporary High Risk Health Insurance Pool Program

I, Peter B. Davidson, am associated with the firm PricewaterhouseCoopers. I am a Member of the American Academy of Actuaries and meet its qualification standards to attest to the actuarial soundness of the projections in the cost proposal submitted by the State of California to the United States Department of Health and Human Services (HHS) for the establishment of a Temporary High Risk Health Insurance Pool Program. I have been retained by the State of California to assist in the development of actuarial projections and to prepare an actuarial attestation of the Cost Proposal for the California Temporary High Risk Health Insurance Pool Program for filing with HHS. The cost proposal covers program enrollment from September 1, 2010 through December 31, 2013, with consideration of claims runout and other continuing costs through 2014.

In the development of California's cost proposal, it is my opinion that reasonable and appropriate methods and assumptions were applied to estimate future enrollment levels, premium revenue, and claims costs. Detailed descriptions of the methodology and assumptions used in the development of the projections are contained in reports provided to the Managed Risk Medical Insurance Board (MRMIB) and are available for HHS review upon request. I believe that the cost proposal has been developed in accordance with generally accepted actuarial principles and practices, complies with the requirements of Section 1101 of the Patient Protection and Affordable Care Act and subsequent direction provided by HHS, and is appropriate for the estimated population to be covered, the services to be furnished, and the premiums to be charged under this program. In the development of the values contained in the cost proposal, I relied upon the accuracy of historical state high risk pool enrollment and claims, other data, and assumptions provided by MRMIB and other entities. I reviewed the data for reasonableness; however, I performed no independent verification and take no responsibility as to the accuracy of these data.

The cost proposal to which this certification is attached is based on a projection of future events. Since limited data exist on which to base predicted enrollment levels, risk mix, and claims costs in the Temporary High Risk Health Insurance Pool, it is certain that actual experience will vary from the values contained in the cost proposal. Differences between our projections and actual results depend on the extent to which future experience conforms to the assumptions made for this analysis. Actuarial methods, considerations, and analyses used in developing the cost estimates conform to the appropriate Standards of Practice promulgated from time to time by the Actuarial

Standards Board. Because of the uncertainty associated with the assumptions underlying the cost proposal, I recommend on-going monitoring, and as appropriate, adjustments to the program benefits, subscriber premiums, and/or enrollment to ensure that expenditures under the program do not exceed limits set by HHS.

Peter B. Davidson

Peter B. Davidson, FSA

Member, American Academy of Actuaries